Wichita State University
Center for Community Support and Research

Health Homes Webinar Series: Program Manual & Documents List

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Welcome!

- Webinar Series is presented to highlight tools and resources available to potential Health Home Partners
- Posted on the KanCare website for future reference
- Thank you for calling in! To reduce distraction, please assure that your phone is on mute.
- Enter questions via “Question” box on your screen

Agenda

Highlights of Draft Health Homes Program Manual (Serious Mental Illness) – Becky Ross, KDHE DHCF

Documentation Requirements, Section 11 – Becky Ross & MCO Representative

Q & A – Becky & MCO Representatives

Purposes for Today

- Participants will have:
  - Knowledge of how to access and navigate the Draft Program Manuals for Health Homes
  - Increased understanding of Lead Entity (LE), Health Home Partner (HHP), and Joint Requirements for Health Home participation
  - Increased understanding regarding LE contracts with HHPs
  - Increased understanding of basic Claims Submission & Billing
  - Increased understanding of Documentation Requirements

Overview

- Two State Plan Amendments – Serious Mental Illness (SPA 1) & Chronic Conditions (SPA 2)
- Each has own program manual – each in draft form until CMS approval
- What's different?
  - How the target populations are defined
  - Professional requirements for Health Home Providers (HHPs)
  - Payment

Overview

- What's the same?
  - Six Health Home services
  - Health Home Provider requirements
  - Assignment and enrollment process
  - Referral process
  - Forms
  - Claims submission
  - Grievances and appeals
  - Health Information Technology (HIT) requirements
  - Quality goals & measures

Health Homes Program Manual (Serious Mental Illness) (DRAFT)

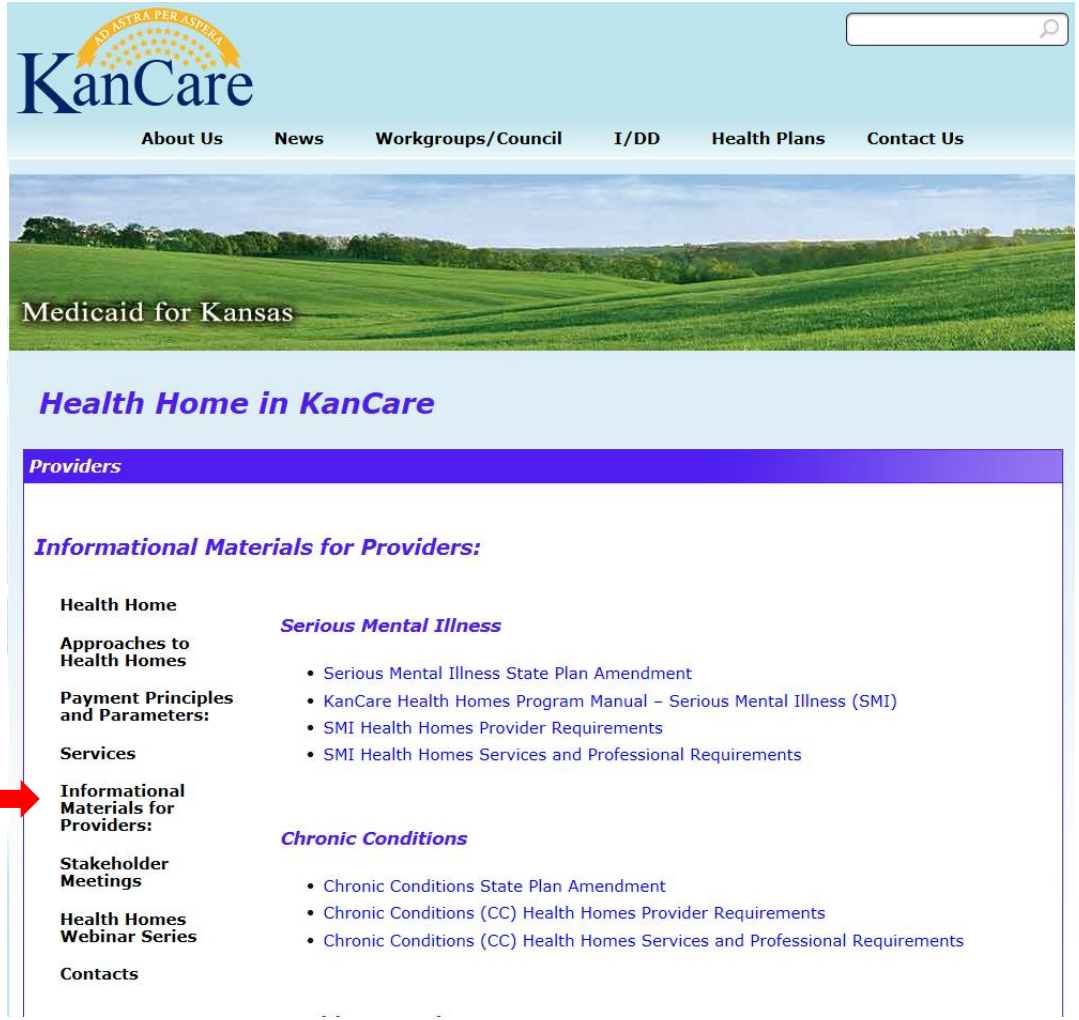
Health Homes Program Manual (SMI)

- This draft focused on State Plan Amendment 1 (SPA 1) for Serious Mental Illness (SMI)
- SPA 2 Manual for Chronic Conditions (CC) still pending
- Will not discuss every section – addressed in future webinars
- To follow review of the actual document, visit http://www.kancare.ks.gov/health_home/providers_materials.htm

KanCare Website

KanCare Website

KanCare Website



Health Homes Program Manual (SMI)

- Section 1 review of the Health Homes Model
- Introduction video available on KanCare website
- Includes outline of Health Home services and professional requirements

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity Requirements

- For all KanCare Health Homes target populations, the requirements for the Lead Entities are the same.
- The Lead Entity must:
  1. Maintain a valid certificate of authority as a Health Maintenance Organization from the Kansas Insurance Department;
  2. Have NCQA accreditation for its Medicaid managed care plan;
  3. Must have authority to access Kansas Medicaid claims data for the population served;
  4. Must have a statewide network of providers to service members with SMI; and,

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity Requirements

- The Lead Entity must:
  5. Must have the capacity to evaluate, select and support providers who meet the standards for HHPs, including:
     a. Identification of providers who meet the HHP standards;
     b. Provision of infrastructure and tools to support HHPs in care coordination;
     c. Gathering and sharing member-level information regarding health care utilization, gaps in care and medications;
     d. Providing outcome tools and measurement protocols to assess HHP effectiveness; and,
     e. Developing and offering learning activities that will support HHPs in effective delivery of HH services.

Section 2 - Provider Requirements for SMI Health Home Participation

Health Home Partner Requirements

- The requirements for Health Home Partners vary, depending upon the target population served by the Health Home; however, every Health Home must include the targeted case management (TCM) provider for any Health Home member who has an intellectual or developmental disability (I/DD).

Section 2 - Provider Requirements for SMI Health Home Participation

Health Home Partner Requirements

- For Health Home members with SMI, the Health Home Partner must:
  1. Meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following:
     a. Center for Independent Living
     b. Community Developmental Disability Organization
     c. Community Mental Health Center
     d. Community Service Provider – for people with intellectual / developmental disabilities (I/DD)
     e. Federally Qualified Health Center/Primary Care Safety Net Clinic
     f. Home Health Agency

Section 2 - Provider Requirements for SMI Health Home Participation

Health Home Partner Requirements

- For Health Home members with SMI, the Health Home Partner must:
  1. Meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following:
     g. Hospital – based Physician Group
     h. Local Health Department
     i. Physician – based Clinic
     j. Physician or Physician Practice
     k. Rural Health Clinics
     l. Substance Use Disorder Provider

Section 2 - Provider Requirements for SMI Health Home Participation

Health Home Partner Requirements

- For Health Home members with SMI, the Health Home Partner must:
  2. Enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements;
  3. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
  4. Provide appropriate and timely in-person care coordination activities.

Section 2 - Provider Requirements for SMI Health Home Participation

Health Home Partner Requirements

- For Health Home members with SMI, the Health Home Partner must:
  5. Have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals;
  6. Agree to accept any eligible enrollees, except for reasons published in Section 4 of this Manual;
  7. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the HHP on care coordination and hospital / ER notification;

Section 2 - Provider Requirements for SMI Health Home Participation

Health Home Partner Requirements

- For Health Home members with SMI, the Health Home Partner must:

8. Commit to the use of an interoperable EHR through the following:
    a. Submission of a plan, within 90 days of contracting as a HHP, to implement the EHR;
    b. Full implementation of the EHR within a timeline approved by the Lead Entity; and,
    c. Connection to one of the certified state HIE, KHIN or LACIE, within a timeline approved by the Lead Entity.

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity and Health Home Partner Joint Requirements

- For all KanCare Health Homes, the Lead Entity and the Health Home Partner must jointly meet several requirements. This means that one or the other must be able to meet the requirement at any one time.

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity and Health Home Partner Joint Requirements

- For Health Home members who are SMI, the Lead Entity and the Health Home Partner must jointly:
  1. Provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees;
  2. Ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay;

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity and Health Home Partner Joint Requirements

- The Lead Entity and the Health Home Partner must jointly:
  3. Ensure person and family-centered and integrated health action planning that coordinates and integrates all his or her clinical and non-clinical health care related needs and services;
  4. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy;

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity and Health Home Partner Joint Requirements

- The Lead Entity and the Health Home Partner must jointly:
  5. Establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers;

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity and Health Home Partner Joint Requirements

- The Lead Entity and the Health Home Partner must jointly:

6. Demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner:
    a. Coordinate and provide the six core services outlined in Section 2703 of the Affordable Care Act;
    b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines;

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity and Health Home Partner Joint Requirements

- The Lead Entity and the Health Home Partner must jointly:
  6. Demonstrate their ability to perform each of the following functional requirements.
     c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
     d. Coordinate and provide access to mental health and substance abuse services
     e. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity and Health Home Partner Joint Requirements

- The Lead Entity and the Health Home Partner must jointly:
  6. Demonstrate their ability to perform each of the following functional requirements.
     f. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and,

Section 2 - Provider Requirements for SMI Health Home Participation

Lead Entity and Health Home Partner Joint Requirements

- The Lead Entity and the Health Home Partner must jointly:
  6. Demonstrate their ability to perform each of the following functional requirements.
     g. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;
  7. Demonstrate the ability to report required data for both state and federal monitoring of the program.

Section 3- Lead Entity Contracts with Health Home Partners

KDHE will require that contracts between the Lead Entities and HHPs contain the following provisions:

- HHPs can limit panels by the number of people served in the Health Home, or to KanCare members already being served or in the provider's panel.
- HHPs are strongly encouraged to provide Care Coordination, Comprehensive Transitional Care and demonstrate the capability of using HIT to link services. The Lead Entity or a subcontractor may provide the other core Health Home services.

Section 7 - Claims Submission and Billing

- A Health Home is considered a bundled service, so individual core services provided within any month will not be billed for as fee-for-service.
- Payment to the Lead Entity, from the State, is a per member per month (PMPM) payment made retrospectively each month and, unless pre-approved by the State, payment to the HHP will be a PMPM.
- HHP must provide the member with at least one Health Home service during the month for which the claim is submitted.

Section 7 - Claims Submission and Billing

- Services should be documented per the information provided in the Section 11: Health Home Documentation Requirements of this manual and as required by the Lead Entity-HHP contract.
- The billing code for any and all Health Home services is **S0281**.
- Information specific to each Lead Entity regarding provider billing is available on the KanCare website at http://www.kancare.ks.gov/provider_billing_information.htm.

Section 11- Health Home Documentation Requirements

Each Lead Entity will have some specific requirements, spelled out in their contracts with HHPs, but all three have agreed to some basic documentation requirements that are designed to demonstrate HHPs have provided specific core Health Home services.

Section 11- Health Home Documentation Requirements

Service	Documentation	Examples of HIT
Comprehensive Care Management	Health Action Plan (HAP) in the patient record; notes in the patient record with date and time (including duration), discussion points with the member or other practitioners, indication that the Plan was shared with all other treating practitioners and others involved in providing or supporting care.	Data or reports used to identify participants assigned to the Health Home by the MCO, used to develop or recommend the Health Action Plan; evidence of sharing the HAP with the participant, other practitioners or the MCO via electronic means
Care Coordination	Patient record entries with date, time, practitioner providing the service, referral, follow-up or coordination activity with the member, treating practitioners and others involved in providing or supporting care. Patient record note could denote an ER visit, hospital admission, phoning member with lab results, discussing a consult with another treating practitioner, etc.	System entries including patient notes; distribution of the HAP or other notes to the MCO; sharing of lab or other results; retrieving information from the MCO to track hospital, ER, and other utilization.
Health Promotion	Health promotion activities document activities to engage member in care, including outreach, assessment of member's health literacy, summary of health education and resources provided.	Evidence of the use of data pulled from the system to identify participant health promotion needs; notes of health promotion interactions; resources to which the participant is directed to address educational and health literacy needs.

Section 11- Health Home Documentation Requirements

Service	Documentation	Examples of HIT
Comprehensive Transitional Care	Documentation in the patient record as to medication reconciliation and other key treatments or services with other health systems/places of service. Documentation should include date, time, practitioner from the HHP and what specific elements of the Health Action Plan, or the Plan itself, were shared and with what other health system or place of service and to achieve which specific Health Action Plan goal. Attention to the appropriate providers to address the follow-up care is extremely important; e.g. transmission of the Health Action Plan to a physical therapist who will be treating a member post knee replacement.	Use of the system to identify admissions, discharge needs, to update HAP based on revised needs, document the scheduling and notification to participants of follow-up appointments.
Individual and Family Support	Documentation of the assessment of psycho-social or community support needs including the identified gaps and recommended resources or resolutions to address the gaps. Date, time, practitioner, service recommendations and discussion with the member, family (or other support persons), and/or guardian should all be included.	Use of the system to share assessment of community support or psychosocial assessments; update of the HAP as applicable to address same; patient record entries; collaboration with other practitioners as to resource information provided or recommended.
Referral to Community and Social Support Services	Documentation in the member record of the date, time and contact at a referral source and/or the date and time that a referral follow through or discussion was convened to address the gaps from the Individual and Family Support assessment process.	Use of the system to share assessment of community support or psychosocial assessments; update of the HAP as applicable to address same; patient record entries; collaboration with other practitioners as to resource information provided or recommended.

Appendices

APPENDIX A: Contact Information

APPENDIX B: Forms (also via www.kancare.ks.gov)

APPENDIX C: Kansas Health Homes Quality Goals and Measures

APPENDIX D: Resources

Questions?

Contact Information

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Save the Dates! *(All sessions 12-1 p.m.)*

- Mar 18 – Member Assignment & Referral Process
- Mar 25 – Payment Structures for SPA 1 & 2
- Apr 22 – Health Action Plan: Step by Step
- Apr 29 – Health Information Technology Basics

Thank you for participating!